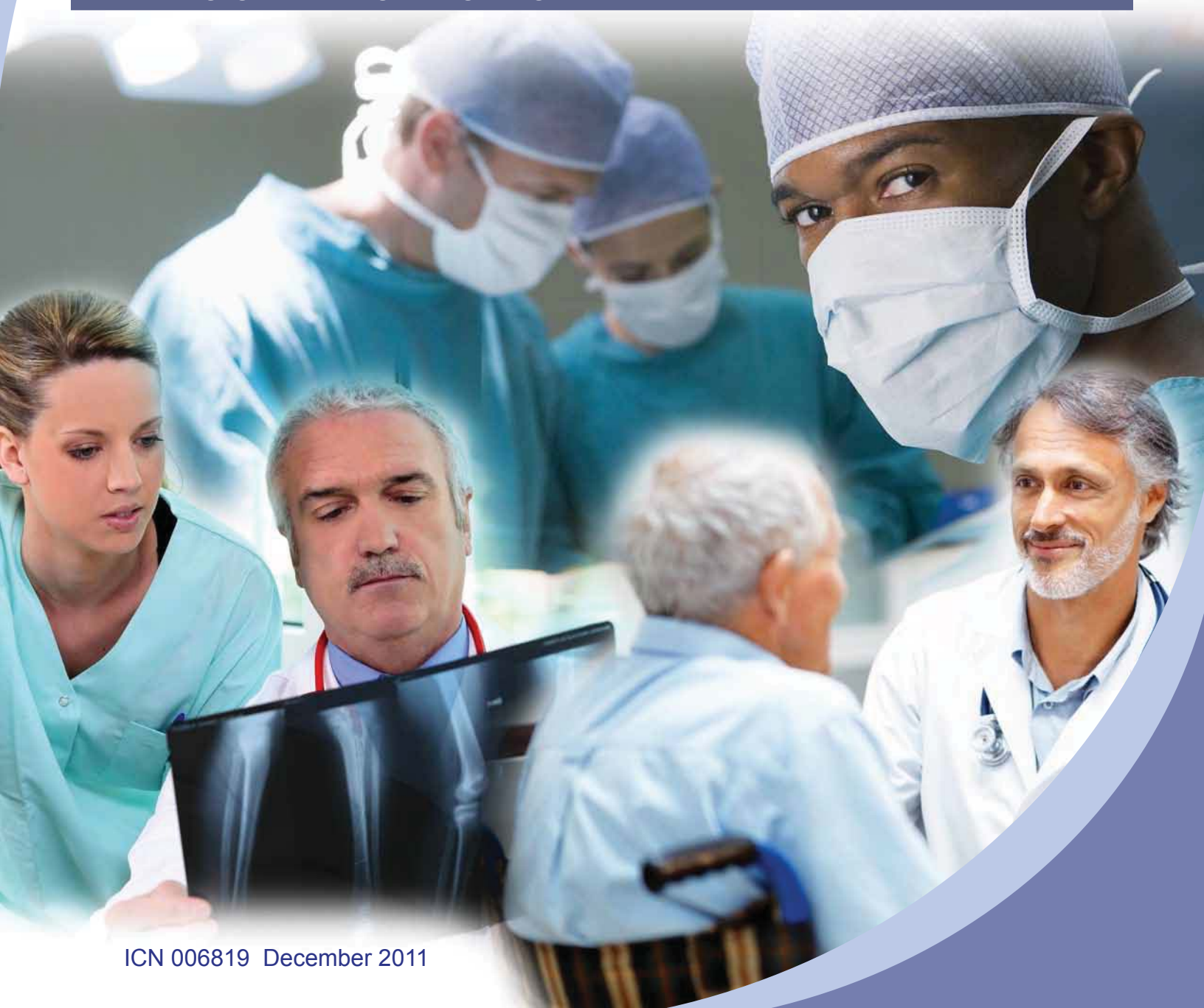
EXHIBIT “F”

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

Ambulatory Surgical Center Fee Schedule

PAYMENT SYSTEM FACT SHEET SERIES



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This publication provides the following information about Ambulatory Surgical Centers (ASC):

- The definition of an ASC;
- ASC payment;
- How payment rates are determined;
- Health care quality; and
- Resources.

Definition of an Ambulatory Surgical Center

An ASC, for Medicare purposes, is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. To be eligible for Medicare payment, ASCs must be certified as meeting the requirements for an ASC and must enter into an agreement with the Centers for Medicare & Medicaid Services (CMS). An ASC can be either:

- Independent (not part of a provider of services or any other facility); or
- Operated by a hospital (under the common ownership, licensure, or control of a hospital). An ASC operated by a hospital must:
  - Be a separately identifiable entity that is physically, administratively, and financially independent and distinct from other operations of the hospital, with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
  - Agree to the same assignment, coverage, and payment rules applied to independent ASCs; and
  - Comply with the conditions for coverage for ASCs.

Ambulatory Surgical Center Payment

Effective January 1, 2008, in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, CMS implemented a revised ASC payment system using the Outpatient Prospective Payment System (OPPS) relative payment weights as a guide. The policies for the revised ASC payment system were made in the ASC final rule (CMS-1517-F), which was published in the "Federal Register" on August 2, 2007. The ASC final rule greatly expanded the types of procedures eligible for payment in the ASC setting and excluded from eligibility only those procedures that pose a significant safety risk to beneficiaries or are expected to require active medical monitoring at midnight when furnished in an ASC. The rule also provided a four-year transition to the fully implemented revised ASC payment rates. Beginning with the November 2007 OPPS/ASC final rule with comment period (CMS-1392-FC), the annual update OPPS/ASC final rule with comment period provides the ASC payment rates and lists of surgical procedures and services that qualify for separate payment under the revised ASC payment system.

Medicare makes a single payment to ASCs for covered surgical procedures, which includes ASC facility services that are furnished in connection with the covered procedure. Examples of covered ASC facility services that are paid through the payment for covered surgical procedures include the following:

- Nursing services, services furnished by technical personnel, and other related services;
- Patient use of ASC facilities;
- Drugs and biologicals for which separate payment is not made under the OPPS, surgical dressings, supplies, splints, casts, appliances, and equipment;

- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies;
- Materials for anesthesia;
- Intraocular lenses;
- Implantable devices, with the exception of those devices with pass-through status under the OPPS; and
- Radiology services for which payment is packaged under the OPPS.

Medicare also pays ASCs separately for covered ancillary services that are integral to a covered surgical procedure billed by the ASC, specifically certain services that are furnished immediately before, during, or immediately after the covered surgical procedure. Covered ancillary services include:

- Drugs and biologicals that are separately paid under the OPPS;
- Radiology services that are separately paid under the OPPS;
- Brachytherapy sources;
- Implantable devices with OPPS pass-through status; and
- Corneal tissue acquisition.

Certain services may be furnished in ASCs and billed by the appropriate certified provider or supplier. The chart below depicts examples of payment and billing for items or services that are not included in ASC payments for covered surgical procedures or covered ancillary services.

Examples Of Items And Services Not Included In ASC Payments For Covered Surgical Procedures Or Covered Ancillary Services

Items Or Services Not Included	Who Receives Payment	Submit Bills To
Physicians' Services	Physician	Carrier or A/B Medicare Administrative Contractor (MAC)
Purchase or Rental of Non-Implantable Durable Medical Equipment (DME) to ASC Patients for Use in Their Homes	Supplier (ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse [NSC])	DME MAC
Non-Implantable Prosthetic Devices	Supplier (ASC can be a supplier of DME if it has a DME supplier number from the NSC)	DME MAC
Ambulance Services	Certified Ambulance Supplier	Carrier or A/B MAC
Leg, Arm, Back, and Neck Braces	Supplier	DME MAC
Artificial Legs, Arms, and Eyes	Supplier	DME MAC
Services Furnished by Independent Laboratory	Certified Laboratory (ASC can receive laboratory certification and a Clinical Laboratory Improvement Amendments number)	Carrier or A/B MAC
Facility Services for Surgical Procedures Excluded From the ASC List (listed in Addendum EE to the OPPS/ASC final rule with comment period)	Not covered by Medicare	Beneficiary is liable